Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 10, 2016

Mr. Daniel Daly, Manager
The Residence At Shelburne Bay East
185 Pine Haven Shores Road
Shelburne, VT 05482-7805

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 16, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1009	A. BUILDING: _____ B. WING _____	C 02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 2/16/16. The following regulatory deficiencies were identified:	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review the facility failed to ensure that services are provided consistent with the physician orders for 1 of 2 residents reviewed (Resident #1). The findings include the following: Per record review for Resident #1, had physician orders dated 12/15/15, for a Prothrombin Time (PTINR) on 1/12/16 at 9:30 AM. A prothrombin time (PT), is a blood test that measures how long it takes blood to clot. PT is also used to check whether medicine to prevent blood clots is working. PT test may also be called a PTINR. Per physician orders dated 12/15/15, Resident #1 was to receive Coumadin, an anticoagulant medication, 3 milligrams (mg) Tuesday/Thursday/Saturday and Coumadin 2 mg Sunday/Monday/Wednesday/Friday. Repeat PTINR January 12, 2016 at 9:30 AM. Per interview with the Resident Care Director,	R128	Resident #1 is no longer at the community. Residents who are receiving PT/INR will be marked on the nurses calendar for follow-up. If the resident gets the lab at the physician's office that will be noted on the calendar as well, so failure to attend appointment will notify nurse that the lab was not drawn. Missed labs will result in calls to physicians to notify and determine treatment plan RCD/Nurses to oversee to ensure compliance and the results to be reviewed at the Communities Quality Assurance meetings.	3/16/16

R128 - R296 POCs accepted 3/10/16 mBertrandRN/pme

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R128	Continued From page 1 confirmation is made that the PTINR was not drawn on 1/12/16 as directed nor has a PTINR been drawn since the 12/15/15 drawing.	R128		
R134 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review for 1 of 2 sampled residents, the facility failed to ensure that, for Resident #2, the initial assessment was completed within 14 days of admission. The findings include the following: Per medical record review on 2/16/16, Resident #2 was admitted on 7/14/14. Registered Nurse signature identifies the assessment was completed on 8/28/14. Per interview with the Resident Care Director on 2/16/15, confirmation is made that the admission assessment was completed 45 days after admission.	R134	R134 Resident #2 assessment has been completed Resident admission assessments will be reviewed weekly for completion until admission assessment is completed. This process to be overseen by RCD/Nurses and reviewed at Communities Quality Assurance Meetings.	3/16/16
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES	R145		

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R145	Continued From page 2 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review the facility failed to ensure that 1 of 2 sampled residents, had a plan of care developed describing care necessary to assist the Resident #1 in maintaining independence and well being. The finding include the following: Per medical record review for Resident #1, the plan of care identifies a problem around Environment Management. Goal is to maintain the room as being free of clutter, dirt and laundry. There are no interventions/tasks identified on the document. Per interview with the Resident Care Director on 2/16/16, Resident #1, liked to keep his/her environment cool. Confirmation is made at this time that the care plan does not identify any concerns with the temperature of Resident #1's room or that s/he liked the room cool. There is no evidence in the nurses notes that identify over the past 11 months, that the resident complained of his/her room being hot nor had staff noted any open windows. Per medical record review, facility internal investigation and interview with the Resident Care Director on 2/16/16, Resident #1 was found lying on the floor in his/her room, unclothed with one of	R145	R145 Resident #1 no longer resides at the Community. Resident Care Plans to be updated to reflect any desire to regularly have room temperature outside of the regulated temperatures. Care Plans to be reviewed with any significant change or annually. RCD/Nurses to oversee to ensure compliance and results brought to Communities Quality Assurance Committee.	3/16/16

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R145	Continued From page 3 two windows open approximately 12 inches wide as demonstrated by a resident care attendant. Per death certificate registered on 1/21/16, Resident #1, died on 1/19/16 due to hypothermia in the setting of environmental (cold) exposure.	R145		3/16/16
R296 SS=D	IX. PHYSICAL PLANT 9.8 Heating 9.8.b The minimum temperature shall be maintained at an ambient temperature of 70 degrees Fahrenheit in all areas of the home utilized by residents and staff during all weather conditions. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to ensure that ambient temperatures are maintained at 70 degrees Fahrenheit in all areas of the home utilized by residents during all weather conditions. The finding include the following: Per interview with the Executive Director on 2/16/16, confirmation is made that the facility does not check ambient temperatures in any areas of the home utilized by residents and staff. Each resident room has it's own thermostat that can be regulated to meet that particular residents needs. Confirmation is also made that there are no temperature logs maintained. (See R-145)	R296	R296 Communities Maintenance Director to audit 5 apartments per week as well as 1 common area to ensure temps are at 70 degrees or higher. The results of these findings will be brought to the Communities Quality Assurance Committee to ensure compliance and the ED/Maintenance Director to oversee this process.	